Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ELISA RIBELLES, MD
P.O. BOX 741865
DALLAS, TX 75374

Respondent Name

AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-0179-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Requester did receive the above mentioned checks. However, as shown by the following EOB the check for $560.00 was for bill #27318 which was for an FCE. According to the documentation provided with RequestorsDWC-60 the other 2 checks sent were for bill #27280 which is the bill in question. The allowable for this case is $850.00 and the total of the 2 checks sent for this bill is $590.00 leaving a balance of $260.00. The Requestor maintains it position that the carrier owes a balance of $260.00."

Amount in Dispute: $260.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier escalated bill for review and payment per applicable fee guidelines. Bill paid in the amount of $1150. All checks have cleared. Please see attached. Please dismiss."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 26, 2010	99456-W5-NM	$260.00	$ 260.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 03, 2010 with reimbursement of $90.00
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

   Explanation of benefits dated June 01, 2010 with reimbursement of $0.00
   - 59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.

Issues

1. Has the Maximum Medical Improvement (MMI) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor billed the amount of $650.00 for CPT code 99456-W5-NM for Designated Doctor Examination for the injured worker not being at Maximum Medical Improvement (MMI), therefore no IR was performed. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00.
2. The respondent has paid $90.00 for CPT code 99456-W5-NM, therefore additional 260.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $260.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $260.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 06, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.